Environments: Centers & Homes
Companion Document

Center/Provider will develop and implement a policy regarding:

Supervision
Caring for Our Children-National Health & Safety Performance Standards (3rd Edition)
http://cfoc.nrckids.org/index.cfm
Chapter 2: Program Activities

2.2 Supervision and Discipline STANDARD 2.2.0.1: Methods of Supervision of Children Caregivers/teachers should directly supervise infants, toddlers, and preschoolers by sight and hearing at all times, even when the children are going to sleep, napping or sleeping, are beginning to wake up, or are indoors or outdoors. School-age children should be within sight or hearing at all times. Caregivers/teachers should not be on one floor level of the building, while children are on another floor or room. Ratios should remain the same whether inside or outside. School-age children should be permitted to participate in activities off the premises with appropriate adult supervision and with written approval by a parent/guardian and by the caregiver. If parents/guardians give written permission for the school-age child to participate in off-premises activities the facility would no longer be responsible for the child during the off-premises activity and not need to provide staff for the off-premises activity. Caregivers/teachers should regularly count children (name to face on a scheduled basis, at every transition, and whenever leaving one area and arriving at another), going indoors or outdoors, to confirm the safe whereabouts of every child at all times. Additionally, they must be able to state how many children are in their care at all times. Developmentally appropriate child: staff ratios should be met during all hours of operation, including indoor and outdoor play and field trips, and safety precautions for specific areas and equipment should be followed. No center-based facility or large family child care home should operate with fewer than two staff members if more than six children are in care, even if the group otherwise meets the child: staff ratio. Although centers often downsize the number of staff for the early arrival and late departure times, another adult must be present to help in the event of an emergency. The supervision policies of centers and large family child care homes should be written policies.

RATIONALE: Supervision is basic to safety and the prevention of injury and maintaining quality child care. Parents/ guardians have a contract with caregivers/teachers to supervise their children. To be available for supervision or rescue in an emergency, an adult must be able to hear and see the children. In case of fire, a supervising adult should not need to climb stairs or use a ramp or an elevator to reach the children. Stairs, ramps, and elevators may become unstable because they can be pathways for fire and smoke. Children who are presumed to be sleeping might be awake and in need of adult attention. A child's risk-taking behavior must be detected and illness, fear, or other stressful behaviors must be noticed and managed. The importance of supervision is not only to protect children from physical injury, but from harm that can occur from topics discussed by children or by teasing/bullying/inappropriate behavior. It is the responsibility of caregivers/teachers to monitor what children are talking about and intervene when necessary. Children like to test their skills and abilities. This is particularly noticeable around playground equipment. Even if the highest safety standards for playground layout, design and surfacing are met, serious injuries can happen if children are left unsupervised. Adults who are involved, aware, and appreciative of young children's' behaviors are in the best position to safeguard their well-being. Active and positive supervision involves: a) Knowing each child's abilities; b) Establishing clear and simple safety rules; c) Being aware of and scanning for potential safety hazards; d) Placing yourself in a strategic position so you are able to adapt to the needs of the child; e) Scanning play activities and circulating around the area; f) Focusing on the positive rather than the negative to teach a child what is safe for the child and other children; g) Teaching children the developmentally appropriate and safe use of each piece of equipment (e.g., using a slide correctly

– feet first only – and teaching why climbing up a slide can cause injury, possibly a head injury). Primary caregiving systems, small group sizes, and low child: staff ratios unique to infant/toddler settings support staff in properly supervising infants and toddlers. These practices encourage responsive interactions and understanding each child's strengths and challenges. When staff connect deeply with the children in their care, they are more in tune to children's needs and whereabouts. Ultimately, carefully planned environments; staffing that supports nurturing, individualized, and engaged caregiving; and well planned, responsive care routines support active supervision in infant and toddler environments. Children are going to be more active in the outdoor learning/ play environment and need more supervision rather than less outside. Playground supervisors need to be designated and trained to supervise children in play areas (1). Supervision of the playground is a strategy of watching all the children within a specific territory and not engaging in prolonged dialog with any one child or group of children (or other staff). Other adults not designated to supervise may facilitate outdoor learning/play activities and engage in conversations with children about their exploration and discoveries. Facilitated play is where the adult is engaged in helping children learn a skill or achieve specific outcome of an activity. Facilitated play is not supervision (2). Children need spaces, indoors and out, in which they can withdraw for alone-time or quiet play in small groups. However, program spaces should be designed with visibility that allows constant unobtrusive adult supervision. To protect children from maltreatment, including sexual abuse, the environment layout should limit situations in which an adult or older child is left alone with a child without another adult present (3,4). Many instances have been reported where a child has hidden when the group was moving to another location, or where the child wandered off when a door was opened for another purpose. Regular counting of children (name to face) will alert the staff to begin a search before the child gets too far, into trouble, or slips into an unobserved location. Caregivers/teachers should record the count on an attendance sheet or on a pocket card, along with notations of any children joining or leaving the group. Caregivers/teachers should do the counts before the group leaves an area and when the group enters a new area. The facility should assign and reassign counting responsibility as needed to maintain a counting routine. Facilities might consider counting systems such as using a reminder tone on a watch or musical clock that sounds at timed intervals (about every fifteen minutes) to help the staff remember to count. Caregivers/teachers should be ready to provide help and guidance when children are ready to use the toilet correctly and independently. Caregivers/teachers should make sure children correctly wash their hands after every use of the toilet, as well as monitor the bathroom to make sure that the toilet is flushed, the toilet seat and floor are free from stool or urine, and supplies (toilet paper, soap, and paper towels) are available. Older preschool children and school-age children may use toilet facilities without direct visual observation but must remain within hearing range in case children need assistance and to prevent inappropriate behavior. If toilets are not on the same floor as the child care area or within sight or hearing of a caregiver/teacher, an adult should accompany children younger than five years of age to and from the toilet area. Younger children who request privacy and have shown capability to use toilet facilities properly should be given permission to use separate and private toilet facilities. Planning must include advance assignments, monitoring, and contingency plans to maintain appropriate staffing. During times when children are typically being dropped off and picked up, the number of children present can vary. There should be a plan in place to monitor and address unanticipated changes, allowing for caregivers/teachers to receive additional help when needed. Sufficient staff must be maintained to evacuate the children safely in case of emergency. Compliance with proper child: staff ratios should be measured by structured observation, by counting caregivers/ teachers and children in each group at varied times of the day, and by reviewing written policies. TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

Safe Sleep Policy
http://idph.iowa.gov/Portals/1/Files/HCCI/safe_sleep_policy.pdf

Playground Equipment Stability and Fall Surfacing
http://idph.iowa.gov/Portals/1/Files/HCCI/playground_surfacing.pdf

Playground Inspection

http://playgroundsafety.org/sites/default/files/report_card_form.pdf

6.2.5 Inspection of Play Areas/ Playgrounds and Equipment STANDARD 6.2.5.1: Inspection of Indoor and Outdoor Play Areas and Equipment The indoor and outdoor play areas and equipment should be inspected daily for the following: a) Missing or broken parts; b) Protrusion of nuts and bolts; c) Rust and chipping or peeling paint; d) Sharp edges, splinters, and rough surfaces; e) Stability of handholds; f) Visible cracks; g) Stability of non-anchored large play equipment (e.g., playhouses); h) Wear and deterioration. Observations should be documented and filed, and the problems corrected. Facilities should conduct a monthly inspection as outlined in Appendix EE, America's Playgrounds Safety Report Card.

RATIONALE: Regular outdoor inspections are critical to prevent deterioration of equipment and accumulation of hazardous materials within the play site, and to ensure that appropriate repairs are made as soon as possible (1,2). Pools of water may cause children to slip and fall. A monthly safety check of all the equipment within the facility as a focused task provides an opportunity to notice wear and tear that requires maintenance.

COMMENTS: Regularity of inspections can be assured by assigning a staff member to check all play equipment to make certain that it is safe for children. Observations should be made while the children are playing, too, to spot any maintenance problems and correct them as soon as possible. If an off-site play area is used, a safety check for hazardous materials within the play area should be done upon arrival to the off-site playground. Hazardous materials may have been left in the play area by other people before the arrival of children from the child care facility. If the playground is not safe, then alternate gross motor activities should be offered rather than allowing children to use equipment that is not safe for them because of hazards. TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 6.2.5.2: Inspection of Play Area Surfacing Loose-fill surfacing materials used to provide impact absorption beneath play equipment should be checked frequently to ensure surfacing is of sufficient depth and has not shifted or displaced significantly, especially in areas under swings and slide exits. Missing or displaced loose fill surfacing should be raked back into proper place or replaced so that a constant depth is maintained throughout the playground. All loose-fill surfacing material, particularly sand, should be inspected daily for: a) Debris (such as glass); b) Animal excrement, and other foreign material; c) Depth and compaction of surface; d) Standing water, ice, or snow. Loose fill surfaces should be hosed down for cleaning and raked or sifted to remove hazardous debris as often as needed to keep the surface free of dangerous, unsanitary materials. Surfacing should be raked to fill in areas of wear (e.g., under swings, bottom of slides, etc.) on a daily basis before use. Check for packing as a result of rain or ice, and if found to be compressed, material should be turned over or raked up to increase resilience capacity. Play should not be permitted on structures in the area if a packed surface cannot be raked up or turned over.

RATIONALE: The number one cause of injury on playgrounds is falls to the surface. Maintaining the correct depth of loose-fill material is crucial for safety. Surfaces should be shock-absorbing (1-3). Cold temperatures may cause "packing," which causes the surface material to lose shock absorbing capacity. Other materials, such as glass, debris, and animal excrement, present potential sources of injury or infection. Maintaining loose fill surfaces provides for proper sanitation

COMMENTS: Surfacing is not tested with ice or snow on it and thus its shock-absorbing and injury-preventing ability is unrated. Therefore, surfacing with ice or snow cannot be relied upon to absorb falls and prevent injuries. Sand is not an appropriate playground covering in areas where pets or animals are a problem. Contact a Certified Playground Safety

Inspector (CPSI) for further guidance. To locate a CPSI, check the National Park and Recreation Association (NPRA) registry at https://ipv.nrpa.org/CPSI_registry/. TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

Exposure Control Plan

http://idph.iowa.gov/Portals/1/userfiles/128/exposure%20control%20plan.pdf

Strangulation Prevention

Caring for Our Children-National Health & Safety Performance Standards (3rd Edition)
http://cfoc.nrckids.org/index.cfm
Chapter 3: Health Promotion
3.4.6 Strangulation STANDARD 3.4.6.1: Strangulation Hazards Strings and cords (such as those that are parts of toys and those found on window coverings) long enough to encircle a child's neck should not be accessible to children in child care. Miniblinds and venetian blinds should not have looped cords. Vertical blinds, continuous looped blinds, and drapery cords should have tension or tie-down devices to hold the cords tight. Inner cord stops should be installed. Shoulder straps on guitars and chin straps on hats should be removed (1). Straps/handles on purses/bags used for dramatic play should be removed or shortened. Ties, scarves, necklaces, and boas used for dramatic play should not be used for children under three years. If used by children three years and over, children should be supervised. Pacifiers attached to strings or ribbons should not be placed around infants' necks or attached to infants' clothing. Hood and neck strings from all children's outerwear, including jackets and sweatshirts, should be removed. Drawstrings on the waist or bottom of garments should not extend more than three inches outside the garment when it is fully expanded. These strings should have no knots or toggles on the free ends. The drawstring should be sewn to the garment at its midpoint so the string cannot be pulled out through one side.

RATIONALE: Window covering cords are associated with strangulation of young children under (2,4). Infants can become entangled in cords from window coverings near their cribs. Since 1990, more than 200 infants and young children have died from unintentional strangulation in window cords (5). Cords and ribbons tied to pacifiers can become tightly twisted, or can catch on crib corner posts or other protrusions, causing strangulation. Clothing strings on children's clothing, necklaces and scarves can catch on playground equipment and strangle children. The U.S. Consumer Product Safety Commission (CPSC) has reported deaths and injuries involving the entanglement of children's clothing drawstrings (3).

COMMENTS: Children's outerwear that has alternative closures (e.g., snaps, buttons, hook and loop, and elastic) are recommended (3). It is advisable that caregivers avoid wearing necklaces or clothing with drawstrings that could cause entanglement. For additional information regarding the prevention of strangulation from strings on toys, window coverings, clothing, contact the CPSC. See http://www.windowcoverings.org for the latest blind cord safety information. RELATED STANDARDS: Standard 5.3.1.1: Safety of Equipment, Materials, and Furnishings TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

Sign-in/sign-out tracking system

Caring for Our Children-National Health & Safety Performance Standards (3rd Edition)
http://cfoc.nrckids.org/index.cfm

Chapter 9 Administration

Standard 9.2.4.7. The facility should have a sign-in/sign-out system to track who enters and exits the facility. The system should include name, contact number, relationship to facility (e.g., parent/guardian, vendor, guest, etc.) and recorded time in and out.

RATIONALE:
This system helps to maintain a secure environment for children and staff. It also provides a means to contact visitors if needed (such as a disease outbreak) or to ensure all individuals in the building are evacuated in case of an emergency.

Oral health-

http://idph.iowa.gov/Portals/1/Files/HCCI/toothbrushing_guide.pdf

Caring for Our Children-National Health & Safety Performance Standards(3rd Edition)
http://cfoc.nrckids.org/index.cfm
Chapter 3: Health Promotion

3.1.5 Oral Health STANDARD 3.1.5.1: Routine Oral Hygiene Activities Caregivers/teachers should promote the habit of regular tooth brushing. All children with teeth should brush or have their teeth brushed at least once during the hours the child is in child care. Children under two years of age should have only a smear of fluoride toothpaste (rice grain) on the brush when brushing. Those over two years of age should use a pea-sized amount of fluoride toothpaste. An ideal time to brush is after eating. The caregiver/teacher should either brush the child's teeth or supervise as the child brushes his/ her own teeth. Disposable gloves should be worn by the caregiver/teacher if contact with a child's oral fluids is anticipated. The younger the child, the more the caregiver/teacher needs to be involved. The caregiver/teacher should be able to evaluate each child's motor activity and to teach the child the correct method of tooth brushing when the child is capable of doing this activity. The caregiver/teacher should monitor the tooth brushing activity and thoroughly brush the child's teeth after the child has finished brushing, preferably for a total of two minutes. Children whose teeth are brushed at home twice a day may be exempted since additional brushing has little additive benefit and may expose a child to excess fluoride toothpaste. The cavity-causing effect of frequent exposure to food or juice should be reduced by offering the children rinsing water after snacks and meals when tooth brushing is not possible. Local dental health professionals can facilitate compliance with these activities by offering education and training for the child care staff and providing oral health presentations for the children and parents/guardians.

RATIONALE: Regular tooth brushing with fluoride toothpaste is encouraged to reinforce oral health habits and prevent gingivitis and tooth decay. There is currently no (strong) evidence that shows any benefit to wiping the gums of a baby who has no teeth. Good oral hygiene is as important for a six-month-old child with one tooth as it is for a six-year-old with many teeth (2). Tooth brushing at least once a day reduces build-up of decay-causing plaque (2,3). The development of tooth decay-producing plaque begins when an infant's first tooth appears in his/her mouth (1). Tooth decay cannot develop without this plaque which contains the acid-producing bacteria in a child's mouth. The ability to

do a good job brushing the teeth is a learned skill, improved by practice and age. There is general consensus that children do not have the necessary hand eye coordination for independent brushing until around age six so either caregiver/teacher brushing or close supervision is necessary in the preschool child. Tooth brushing and activities at home may not suffice to develop this skill or accomplish the necessary plaque removal, especially when children eat most of their meals and snacks during a full day in child care.

COMMENTS: The caregiver/teacher should use a small amount of fluoride toothpaste (a smear about the size of a rice grain spread across the width of the toothbrush for children under two years of age and a pea-sized amount for children two years of age and over). Children should attempt to spit out excess toothpaste after brushing. Fluoride is the single most effective way to prevent tooth decay. Brushing of teeth with fluoridated toothpaste is the most efficient way to apply fluoride to the teeth. Young children may occasionally swallow a small amount of toothpaste and this is not a health risk. However, if children swallow more than recommended amounts of fluoride toothpaste on a consistent basis, they are at risk for fluorosis, a condition caused by ingesting excessive levels of fluoride (6). Other products such as fluoride rinses can pose a poisoning hazard if ingested (7). The children can also rinse with water and spit out after a snack or a meal if their teeth have already been brushed earlier. Rinsing with water helps to remove food particles from teeth, diluting sugars and may help prevent cavities. A sink is not necessary to accomplish tooth brushing in child care. Each child can use a cup of water for tooth brushing. The child should wet the brush in the cup, brush and then spit excess toothpaste into the cup. Caregivers/teachers should encourage replacement of toothbrushes when the bristles become worn or frayed or approximately every three to four months (4,5). Caregivers/teachers should encourage parents/guardians to establish a dental home for their child within six months after the first tooth erupts or by one year of age, whichever is earlier (1). The dental home is the ongoing relationship between the dentist and the patient, inclusive of all aspects of oral health care delivered in a comprehensive, continuously accessible, coordinated and family-centered way. Currently there are insufficient numbers of dentists who are able to incorporate infants and toddlers into their practices so primary care providers may provide oral health screening during well child care in this population while promoting the establishment of a dental home (2). Fluoride varnish applied at primary care visits reduce decay rates by one-third, and lead to significant cost savings in restorative dental care and associated hospital costs. Coupled with parent/guardian and caregiver/teacher education, fluoride varnish is an important tool to improve children's health (8,9). TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home

STANDARD 3.1.5.2: Toothbrushes and Toothpaste In facilities where tooth brushing is an activity, each child should have a personally labeled, age-appropriate toothbrush. No sharing or borrowing should be allowed. After use, toothbrushes should be stored on a clean surface with the bristle end of the toothbrush up to air dry in such a way that the toothbrushes cannot contact or drip on each other and the bristles are not in contact with any surface (6). Racks and devices used to hold toothbrushes for storage should be labeled and disinfected as needed. The toothbrushes should be replaced at least every three to four months, or sooner if the bristles become frayed (2-4,6). When a toothbrush becomes contaminated through contact with another brush or use by more than one child, it should be discarded and replaced with a new one. If toothpaste is used, each child should have his/her own labeled toothpaste tube. If toothpaste from a single tube is shared among the children, it should be dispensed onto a clean piece of paper or paper cup for each child rather than directly on the toothbrush (1,6). Children under two years of age should have only a smear of fluoride toothpaste (rice grain) on the brush when brushing. Those over two years of age should use a pea-sized amount of fluoride toothpaste. Toothpaste should be stored out of children's reach. When children require assistance with brushing, caregivers/teachers should wash their hands thoroughly between brushings for each child. Caregivers/teachers should wear gloves when assisting such children with brushing their teeth.

RATIONALE: Toothbrushes and oral fluids that collect in the mouth during tooth brushing are contaminated with

infectious agents and must not be allowed to serve as a conduit of infection from one individual to another (6). Individually labeling the toothbrushes will prevent different children from sharing the same toothbrush. As an alternative to racks, children can have individualized, labeled cups and their brush can be stored bristle-up in their cup. Some bleeding may occur during tooth brushing in children who have inflammation of the gums. In child care, saliva is considered an infectious vehicle if it contains blood, so caregivers/ teachers should protect themselves from exposure to blood in such situations, as required by standard precautions. The Occupational Safety and Health Administration (OSHA) regulations apply where there is potential exposure to blood.

COMMENTS: Children can use an individually labeled or disposable cup of water to brush their teeth (6). Toothpaste is not necessary if removal of food and plaque is the primary objective of tooth brushing. However, no anti-caries benefit is achieved from brushing without fluoride toothpaste. Some risk of infection is involved when numerous children brush their teeth into sinks that are not sanitized between uses. Toothbrushing ability varies by age. Preschool children most likely will require assistance. Adults helping children brush their teeth not only help them learn how to brush, but also improve the removal of plaque and food debris from all teeth (5). TYPE OF FACILITY: Center; Large Family Child Care Home; Small Family Child Care Home RELATED STANDARDS: Standard 3.1.5.1: Routine Oral Hygiene Activities Standard 3.1.5.3: Oral Health Education Standard 3.6.1.5: Sharing of Personal Articles Prohibited Standard 5.5.0.1: Storage and Labeling of Personal Articles

STANDARD 3.1.5.3: Oral Health Education All children with teeth should have oral hygiene education as a part of their daily activity. Children three years of age and older should have developmentally appropriate oral health education that includes: a) Information on what plaque is; b) The process of dental decay; c) Diet influences on teeth, including the contribution of sugar-sweetened beverages and foods to cavity development; and d) The importance of good oral hygiene behaviors. School-age children should receive additional information including: a) The preventive use of fluoride; b) Dental sealants; c) Mouth guards for protection when playing sports; d) The importance of healthy eating behaviors; and e) Regularly scheduled dental visits. Adolescent children should be informed about the effect of tobacco products on their oral health and additional reasons to avoid tobacco. Caregivers/teachers and parents/guardians should be taught to not place a child's pacifier in the adult's mouth to clean or moisten it or share a toothbrush with a child due to the risk of promoting early colonization of the infant oral cavity with Streptococcus mutans (5). Caregivers/teachers should limit juice consumption to no more than four to six ounces per day for children one through six years of age.

RATIONALE: Studies have reported that the oral health of participants improved as a result of educational programs (1).

COMMENTS: Caregivers/teachers are encouraged to advise parents/guardians on the following recommendations for preventive and early intervention dental services and education: a) Dental or primary care provider visits to evaluate the need for supplemental fluoride therapy (prescription pills or drops if tap water does not contain fluoride) starting at six months of age, and professionally applied topical fluoride treatments for high risk children (4); b) First dental visit within six months after the first tooth erupts or by one year of age, whichever is earlier and whenever there is a question of an oral health problem; c) Dental sealants generally at six or seven years of age for first permanent molars, and for primary molars if deep pits and grooves or other high risk factors are present (2,3). Caregivers/teachers should provide education for parents/ guardians on good oral hygiene practices and avoidance of behaviors that increase the risk of early childhood caries, such as inappropriate use of a bottle, frequent consumption of carbohydrate-rich foods, and sweetened beverages such as juices with added sweeteners, soda, sports drinks, fruit nectars, and flavored teas.